

VIRGINIA DEPARTMENT OF HEALTH ADAP MEDICATION EXCEPTION FORM

DO.B. (mm/dd/yy):	PATIENT NAME (Last, First,	MI):								
RACEETHNICITY: White (non-Hispanic) African American/Black (non-Hispanic) Hispanic Asian/Pacific Islander American Indian, Aleutian, Eskimo Unknown HEALTH DEPARTMENT PHONE # HEALTH DEPARTMENT FAX # LOCAL HEALTH DEPARTMENT ADAP CONTACT PERSON: PRESCRIBING PHYSICIAN NAME: PHYSICIAN PHONE #: FORM COMPLETED BY (Name): TITLE: DATE (mm/dd/yy): MEDICATION REQUESTED: REASON FOR EXCEPTION: Specify other anti-retroviral medications patient is currently on (fuzeon should be added to current therapy) NAME OF MEDICATION DOSE DATE STARTED DATE DISCONTINUED ABORATORY HISTORY Please star with the most current results (give at least two (2) results if available) VIRAL LOAD RESULTS DATE CD4 COUNT RESULTS DATE VODH USE ONLY Request Approved Request Denied Rational: Request Denied Request Denied Rational: Reque	D.O.B. (mm/dd/yy):	-	AGE:		SEX:	X: MALE FEMALE				
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Fax to CENTRAL ADAP office, ADAP Coordinator at (804) 864-8050

